



Medical History

Name: _____ DOB: _____

What is your understanding of what is wrong with you? _____

What are your specific goals for therapy? _____

Are you taking any medications? Please list: _____

HISTORY (Please check ALL that apply to you currently or in the past)

- Cancer
- Mental illness
- Stroke
- Allergic to latex
- Infections
- Incontinence
- Smoke cigarettes
- Diabetes
- Other medical problems we should know about: _____
- I require in-home assistance
- Breathing/lung problems
- Liver or kidney problems
- Seizures
- Current pregnancy
- Osteoarthritis
- Rheumatoid arthritis
- Osteoporosis
- Problems with thinking or memory
- Problems with speech/hearing/vision
- Neurological issues (MS/Parkinson's/other)
- Heart problems (high blood pressure/angina/heart attack)
- Endocrine problems (thyroid/other)
- Exercise _____ days per week for _____ minutes
- Surgeries: _____

The following activities ARE made more difficult by this problem:

- Sleeping
- In/Out of Bed
- Bathing
- Dressing
- Hair/Teeth
- Laundry
- Vacuuming
- Stairs
- Twisting
- Bending
- Lifting
- Squatting
- Sitting
- Standing
- Driving
- Walking
- Jogging/Running
- In/Out of vehicle

Please check all that apply to this problem:

- This is a work related injury Work duties that are affected: _____

I have been evaluated/treated by:

- Primary Care Physician
- Acupuncturist
- Other: _____
- Specialist Physician
- Massage Therapist
- Physical Therapist # of visits: _____ When: _____
- Chiropractor
- Osteopath

- I have had recent special tests: X-rays MRI/A CT scan Other: _____

How did you hear about The Edge Physical Therapy? (Check all that apply)

- Primary Care Physician
- Specialist Physician
- Phone book listing
- Friend
- Radio ad
- Newspaper ad
- EDGE Employee
- EDGE PT website
- I am a returning patient
- Television ad
- EDGE website
- I am a member of EDGE